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MEDICAL REPORT
REGARDING CHILD TO BE ADOPTED

SECTION A: REPORT BY CARETAKER(S)/ADOPTING PARENT(S) (To be filled out by caretaker(s) or adopting parent(s) before physician's examination.)

☐ First Medical Report for Independent Adoption

☐ Second Medical Report for Independent Adoption (Required for infant adoptions when the minor is at least 5 months old)

☐ Sole Medical Report for Agency Adoption

IDENTIFYING INFORMATION

NAME(S) OF CARETAKER(S)/ADOPTING PARENT(S)

NAME OF CHILD	DATE OF BIRTH	SEX

BIRTH INFORMATION

LENGTH OF TERM	TYPE OF DELIVERY	LENGTH AT BIRTH	BIRTH WEIGHT

BIRTH COMPLICATIONS: (Note any complications such as in utero drug or alcohol exposure, birth injury, jaundice, etc.)

NUTRITION/DEVELOPMENT/PERSONALITY

NUTRITION: (Note eating habits and any problems such as food allergies, eating disorders, poor appetite, constipation, etc.)

DEVELOPMENTAL HISTORY: (Note any developmental delays or history of abuse and/or neglect. Describe child's general development.)

PERSONALITY: (Note child's personality traits. For example, is the child calm, restless, aggressive, anxious, shy, happy, etc.?)

Is the child allergic to any medications? ..... ☐ **YES** ☐ **NO**

If YES, what medications:

	YES	NO		YES	NO		YES	NO
Allergy-Asthma	☐	☐	Measles-Rubiola	☐	☐	Polio	☐	☐
Chicken Pox	☐	☐	Measles-German	☐	☐	Seizures	☐	☐
Frequent Colds	☐	☐	Scarlet Fever	☐	☐	Pneumonia	☐	☐
Ear Infections	☐	☐	Whooping Cough	☐	☐	Hepatitis	☐	☐
Blood Disorder	☐	☐	Rheumatic Fever	☐	☐	Tuberculosis	☐	☐
Other:								

SECTION B: REPORT BY PHYSICIAN WHO PERFORMED PHYSICAL EXAMINATION OF CHILD

LENGTH	WEIGHT	CHEST	HEAD

PHYSICAL EXAMINATION

_____	Nutrition	_____	Nose	_____	Lungs
_____	Skin	_____	Mouth & Throat	_____	Abdomen
_____	Head	_____	Teeth	_____	Hernia
_____	Eyes	_____	Neck & Glands	_____	Genitalia
_____	Ears	_____	Chest	_____	Extremities
_____	Vision	_____	Heart	_____	Other

LABORATORY TEST

Blood Serology:	DATE & RESULTS:	
		☐ MEDICALLY NOT INDICATED
Toxicology Screen:	DATE & RESULTS:	
		☐ MEDICALLY NOT INDICATED
PKU/Newborn Screen:	DATE & RESULTS:	
		☐ MEDICALLY NOT INDICATED
Other Lab Tests:	TYPE, DATE & RESULTS:	

Did you detect any factors that would indicate a medical condition, injury, development delay, or genetic predisposition that would put this child at risk either currently or in the future? . . . . . ☐ YES ☐ NO
If YES, explain:

Medication taken regularly? . . . . . ☐ YES ☐ NO
If YES, describe:

Is the child's immunization record current? . . . . . ☐ YES ☐ NO
If NO, what immunizations are needed?

Does the child present any physical, emotional or behavioral signs of physical abuse, sexual abuse or neglect? . . . . . ☐ YES ☐ NO
If YES, explain:

How many times have you seen this child?_____, Does it appear as if the child is being parented in a way that meets his/her medical and developmental needs? . . . . . ☐ YES ☐ NO
If NO, explain:

Diagnosis and Recommendation:

PHYSICIAN'S NAME	EXAMINATION DATE:

ADDRESS:

SIGNATURE:	PHONE NUMBER:
	( )